

## Choice and chance in low risk maternity care

### *General practitioner obstetrics back on the agenda*

"Will I still have a choice about where I have my baby? Yes."<sup>1</sup>

Despite claims that "under the new arrangements . . . popular cottage hospitals will thrive"<sup>2</sup> closures of small maternity units continue in line with the view that every woman should give birth in a district general hospital. As a result, in many parts of the country choice has been narrowing rather than widening. Between 1980 and 1990 the number of isolated general practitioner maternity units in the United Kingdom halved (from 212 to 106) while the number of units offering both general practitioner and consultant care fell slightly (from 121 to 115).<sup>3</sup> This might be interpreted as meaning that women preferred consultant care, but many of the closures were met with vociferous and concerted opposition from the users of the units.

Only 6% of deliveries in England and Wales were booked for general practitioner care in 1988,<sup>4</sup> compared with 15% in 1975 and 50% in 1946.<sup>5</sup> In 1988, 31% of hospital deliveries for which general practitioners had overall responsibility took place in separate units alongside consultant units, with 42% in fully integrated units and 27% in isolated units.<sup>4</sup> Lack of local facilities, absence of incentives, inappropriate training, and low confidence may mean that this form of care becomes extinct despite the efforts of the professionals concerned, who have formed an association, recently renamed the Association for Community-based Maternity Care, to defend it.<sup>6</sup>

Last year the *BMJ* published two papers presenting data from integrated<sup>7</sup> and isolated<sup>8</sup> units, suggesting that general practitioner obstetrics is less safe than care offered by consultant obstetricians. These conclusions run counter to a substantial body of evidence from elsewhere.<sup>6,9-18</sup> A paper from Bradford failed to distinguish between deaths that could and could not have been prevented by better care and failed to take account of possible differences in the socioeconomic background of women booked for consultant and general practitioner care.<sup>7,19</sup> Together with subsequent correspondence<sup>20-22</sup> it identified problems of communication between professionals in Bradford. The paper's conclusions should therefore not be extrapolated elsewhere. It is encouraging to see that the general practitioners describing the outcome of planned births in this issue acknowledge cooperation and support from senior hospital doctors (p 1517).<sup>23</sup>

The authors of the other controversial study restricted their comparison of mortality in different types of unit to normal deliveries by excluding multiple births and all babies with

lethal congenital malformations or birth weights under 2500 g.<sup>8</sup> Antepartum stillbirths were included, although deciding whether the place of birth was relevant to this outcome is impossible without more details of each case.<sup>24</sup> The authors also failed to take account of risk factors other than parity.<sup>25,26</sup> They reported higher perinatal mortality rates in the isolated units than in the integrated unit or the consultant unit for nulliparous and multigravid women and for both groups combined, and the  $\chi^2$  tests showed that the differences were significant. In each of the three tests, however, one of the cells had an expected value of less than five. This means they should be interpreted with extreme caution and do not provide an adequate basis on which to recommend major changes in practice.<sup>26</sup>

Figures from the Office of Population Censuses and Surveys show that from 1975 to 1987 mortality for births in hospitals without obstetric units were low and fell in line with the rates for all births.<sup>27,28</sup> Although these data do not identify women who booked for general practitioner units but transferred to consultant units, studies that have done so have shown that mortality in general practitioner units is low.<sup>10-12</sup>

These studies do not attempt to control for selection biases, but several others have tried to do this by comparing groups of low risk women delivering with different forms of care.<sup>13,14</sup> Unlike the recent study from the Bath district,<sup>8</sup> these failed to show that increased mortality was associated with general practitioner deliveries. Furthermore, a review of many such studies, mainly from the United Kingdom and North America, found only one where general practitioner care was associated with poorer outcome.<sup>15</sup> Marjorie Tew has even claimed that general practitioner care is associated with lower mortality for high as well as low risk women,<sup>29,30</sup> but the nature of the selection processes and the predictive ability of the prediction scores she used has been questioned.<sup>9,31</sup>

Few studies of morbidity in mothers and babies have been done. Two studies comparing similar groups of low risk women delivering in hospital under general practitioner and consultant care found that higher morbidity was associated with consultant care.<sup>32,33</sup> Those comparing home and hospital births, including two restricted to low risk women, produced similar findings.<sup>34,35</sup>

The view that large hospitals are safer has been widely accepted<sup>36</sup> without critical examination of the evidence.<sup>9</sup> Some research from other countries suggests that larger babies actually do worse in larger hospitals,<sup>37-39</sup> although an Australian study found the opposite.<sup>40</sup>

A recent study confirmed the well established finding that a considerable demand exists for care other than that found in consultant obstetric units.<sup>41</sup> Nearly all studies of women who have experienced both home and hospital births have indicated strong preferences for home delivery, although once again, there are problems with selection biases.<sup>9</sup> No evidence exists that they are just "fuddy duddy middle class mothers" as has been suggested.<sup>42</sup> The experience of the general practitioners writing in this issue is that a substantial number of working class women will opt for home birth if the service is available and they are now receiving requests for it from Moslem women.<sup>23</sup>

A common reason advanced for closing isolated general practitioner maternity units is cost, often in response to short term financial problems, with some closures being classed as "cost improvement programmes." Ironically, this contrasts with what is happening in the United States, where "out of hospital birth centres" are just beginning to find favour on the grounds of cheapness. A review of the few studies done in the United Kingdom has found no evidence that general practitioner maternity care is uneconomic for the public sector or for its users.<sup>43</sup> A statutory requirement exists to provide a domiciliary midwifery service, and if this is integrated with hospital and community services no additional staff are needed. Closing small units, on the grounds of "rationalisation," will probably result in costs being transferred from the NHS to families, social services, or social security. The NHS may actually lose resources raised by volunteers as they may not transfer their support to the district general hospital when a small unit closes.<sup>43</sup>

## Parents want choice

Parents are looking for choice, and ways must be found to provide it safely and economically to fulfil the government's promise that health authorities "will aim to provide you and your general practitioner with the maximum choice."<sup>1</sup> A positive step would be formally to recognise and enhance the role of midwives as specialists in normal delivery and experiment with new arrangements, such as midwifery care wards.<sup>44</sup> The role of general practitioners in normal delivery should be reviewed.<sup>45</sup> In many cases already the term "general practitioner delivery" is a misnomer as most such deliveries are normal, taking place under the supervision of midwives with variable input from general practitioners.

Training is also important. Although most entrants to general practice have some training in obstetrics, it is mainly in consultant units. A chance to experience maternity care in a low technology setting should be part of the training of all general practitioners and midwives. The further problem of maintaining skills could be approached by interchange of midwifery staff between different types of unit and expanding the numbers of clinical assistant and hospital practitioner appointments. The latter would provide general practitioners who are regularly involved in intrapartum care with an opportunity to maintain and develop their skills, while also assisting staffing of obstetric departments by providing relatively long term appointments at subconsultant level. Finally, transfer of women during pregnancy should not be all one way. Women referred to obstetricians for investigation of problems should be transferred back to the care of their general practitioner or midwife if consultant care is not required.

To fulfil the government's promise of choice attention must be refocused on the needs of the majority of women who are unlikely to need an obstetrician at delivery and whose babies are at low risk of developing problems. Wherever women choose to deliver, midwives will provide most of their care,

although some general practitioners may still want to be involved. Suitably organised and rewarded, this can be only to the benefit of all concerned, including the hard pressed consultant service.

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